July 31, 2025

LABOR REPRESENTATIVES
PLAN DESIGN COMMITTEE PROPOSALS
FY2026 SHBP Cost Reductions

As required by the FY2026 State Budget, the Labor Representatives of the SHBP Plan Design Committee submit the following reforms to reduce costs for the SHBP, for employees, and for employers. Our proposals do not scapegoat or shift costs onto employees as the solution to rising costs and lack of pricing transparency from the TPAs. Our proposals will result in significant, sustained cost reductions for the plan and its participants. These reforms will allow local governments to regain trust in management of the SHBP. We urge the State to adopt them and take all necessary steps to expedite implementation. If this is a crisis, it deserves fast and commensurate remedies.

These proposals are subject to amendment and to being supplemented by the labor representatives. We are still waiting for requested information that is essential to preparing these submissions. The original request was submitted on July 9, and among other things it sought claims data that was essential to our review. That granular level of detailed information, as well as other requested information, has not been provided. Further, we only received a set of documents on July 29 and are still analyzing the information. Thus, we are submitting this to meet the deadline, but providing notice that it is subject to amendment and change. We await the scoring of these proposals by Aon and request a full analysis, showing the actuarial reasons for any scoring conclusions that are reached.

Fiscal Year 2026 Appropriations Act (P.L.2025, c.74), Resolution 1389:

> Notwithstanding the provisions of any law or regulation to the contrary, the appropriations for the Employee Benefits program classification shall be subject to the following conditions:
>
> (1) in a good faith effort to agree on proposals to save a total of $100 million in State funds during the first six months of Plan Year (PY) 2026, the State and public employees' representatives on the State Health Benefits Plan Design Committee (SHBPDC) shall separately submit cost savings proposals to the plan actuary by July 31, 2025 and the plan actuary shall review the proposals to determine whether the plan design proposals will result in recurring and actuarially verifiable cost savings, noting whether they will be achieved in the first six months of PY 2026 in the amount of $100 million. Any proposal that the plan actuary determines will not result in recurring and actuarially verifiable cost savings, or less cost savings than proposed, in the first six months of PY 2026 shall be adjusted to reflect actuarially verified cost savings or eliminated from further consideration if no savings are actuarially verified. The SHBPDC shall then meet and vote on each of the verified proposals before September 30, 2025;
>
> (2) if the plan actuary determines that the cost savings proposals submitted by the labor and administration representatives will not result in recurring and verifiable

total savings of at least $100 million during the first six months of PY 2026, the labor and administration representatives on the SHBPDC shall submit additional proposals to the plan actuary in an effort to achieve the $100 million savings target before September 30, 2025;

(3) if the SHBPDC is unable to reach agreement on the actuarially verified proposals totaling $100 million in cost savings before September 30, 2025, the SHBPDC shall immediately commence the existing statutorily prescribed mediation and conciliation procedure set forth in P.L.2011, c.78, and that process shall be concluded by October 31, 2025;

(4) if the SHBPDC is unable to reach agreement on cost savings proposals totaling $100 million in actuarially verified savings following the existing statutorily prescribed mediation and conciliation procedure set forth in P.L.2011, c.78, the Legislature shall revise the statutory framework set forth in P.L.2011, c.78 to determine a process by which $100 million in actuarially verifiable cost savings shall be achieved for PY 2026 before December 1, 2025;

(5) if the Legislature does not pass a bill revising the statutory framework before December 1, 2025, then a representative of the State selected by the Governor and a public employees' representative selected by the State employees' and local employees' representatives on the SHBPDC shall jointly select cost-saving changes to achieve $100 million in actuarially verifiable cost savings. In the event that the State representative and the public employees' representative are unable to reach agreement, then the Executive Director of the Office of Legislative Services shall designate an additional representative and the three representatives shall meet and vote to select cost-saving changes to achieve $100 million in actuarially verifiable cost savings for the first six months of PY 2026 before December 15, 2025.

A. <u>Adjustment of 2026 Premium Rate Recommendation</u>

1. We note the rate recommendations for State and Local Government groups issued by the Plan Actuary on July 9, 2025 do <u>not</u> include the $200 million reduction as set forth in the FY2026 budget.

The Plan Actuary presented multiple scenarios for Local Government premium rates including the current statutory requirement for the local government part to repay $200 million to the state part. This requirement is statutory.

However, the rates for the State group do not reflect a $200 million reduction as required under the statutory language of the FY2026 budget.

→ *Labor representatives of the Plan Design Committee request a revised rate recommendation to be issued for the State group no later than August 15, 2025*.

2. **Outcomes and agreements from the NJ State bargaining unit reopener tables that require PDC approval shall be credited towards the FY2026 budget requirement and shall be scored to reduce premiums for PY2026.**

3. **Claims Review – mandate review of not less than 50% of all claims, in and out of network, and at least 50% of out of state claims.**

The current claims review vendor has recouped an average of $50 million (net of all fees) each full plan year, and a total of $231 million since onboarding during 2021. Through June 1, 2025, claims review has already saved over $28 million net of fees. Yet, this is only scratching the surface and the claims review contract allows for a larger number of reviews. Additionally, out of state services are not provided for review.

Using data analytics, claims reviewers can identify an appropriate number and types of claims to review effectively. Labor representatives have advocated strongly for claims review and continue to recommend at least 50% of all claims reviewed. Every review that results in discovery of an incorrect payment is a return of public tax dollars that would have been inappropriately spent. The State has a legal and fiduciary obligation to audit and claw back incorrect overpayments to any vendor, and health insurance charges are currently under-scrutinized.

→ *All savings must be transparently scored by the Plan Actuary in the premium rate analysis to reduce PY2026 premiums and a report provided to the SHBC and PDC no later than August 15.*

B. <u>Control Medical and Hospital Prices</u>

1. Implement Reference Based Pricing across all SHBP Plans

The savings from Reference Based Pricing is too significant to ignore, to claim is too hard to implement, or to put off any longer. Labor and management may differ on the reasons and decisions that led to the current SHBP crisis, but we should agree that the crisis demands bold action. It cannot be business as usual. Cost increases are the main driver of premium rates exploding in the past few years. The State must use its size to negotiate better prices, including indexed or reference-based pricing as other states have done, to create savings for taxpayers, pubic employees, and public employers.

Data provided by CWA shows other states that have implemented reference-based pricing have achieved significant, sustainable savings to the employer and employees without cost-shifting.

State	Period	Service	Savings
California	2011-2013	Knee Replacement Surgery	26.7%
California	2008-2012	Knee and Hip Replacement surgery	20.2%
California	2009-2012	Cataract Surgery	17.9%
California	2012-2014	Knee Arthroscopy	17.6%
California	2012-2014	Shoulder Arthroscopy	17.0%
California	2013-2015	Colonoscopies	21.0%

Montana	2017-2019	Inpatient Services	21.0%
Montana	2017-2019	Outpatient Services	11.0%
Oregon	2019-2020	Hospital Services	14.0%
Oregon	2021	Hospital Services	33.0%

Had New Jersey implemented indexed pricing for medical and hospitalization services earlier, we would not have experienced the dramatic annual increases of the past five years.

No balance billing:
The SHBP plan designs and the State's contracts with TPAs, carrier, or providers shall not permit a medical provider or hospital to bill or collect from a covered employee or dependent any charges in excess of the reimbursed amount paid by the Plan.

In Network: For all plans offered under the SHBP to State and Local Government employees, the reimbursement rates for in network medical and hospital services shall be paid as the lesser of (a) the billed charges; (b) the third-party administrator's contracted rate for the medical or hospital service; or (c) 200% of Centers for Medicare and Medicaid Services (CMS) allowances.

Out of Network:
For all plans with out of network coverage, offered under the SHBP to Local Government employees, the reimbursement rates for out of network medical and hospital services shall be paid by the State as the lesser of (a) the billed charges; (b) the third-party administrator's contracted rate for the medical or hospital service; or (c) 200% of Centers for Medicare and Medicaid Services (CMS) allowances.

→ *Labor submits reference-based pricing of 200% CMS in network and 200% CMS out of network to the Plan Actuary for scoring, assuming an implementation during the first six months of Plan Year 2026. Whether this is implemented through contracting with current providers or through another method, the Plan Actuary should provide a savings and impact analysis pursuant to the FY2026 budget requirement.* ***The Plan Actuary must score this proposal, it is not the authority on contracting or procurement procedures.***

→ *The Plan Actuary should score the above RBP as described above were implemented effective January 1, February 1, March 1, and April 1, 2026 to provide multiple scenarios and scoring to the PDC for consideration.*

2. High-Deductible Plans
Incentivize employee voluntary selection of HDHP plans.

→ *Provide incentives attached to lower cost plans, including HDHPs, by offering lower employee contribution rates and increased HRA and HSA plans. The Plan Actuary shall score options including reducing employee contributions and providing HSA/HRA plans.*

3. Implement site neutral payments.

This occurs when a charge at a medical practice affiliated with a hospital is billed as a hospital visit rather than a primary or specialist office visit.

We understand the State's assertion that contract enforcement and claims review procedures are in place to catch inappropriate payment coding. However, both Labor and the State acknowledge the claims review process does not review every claim.

→ *Plan-wide site neutral payments should be mandated by the PDC and SHBC. The Plan Actuary should score implementation of site neutral payments effective January 1, 2026.*

4. **Require and audit appropriate emergency room coding** (e.g. claim coded as ER admission when treated and discharged).

5. **Implement Center of Excellence for Certain Surgical Procedures and score savings starting January 1, 2026**

In 2024, the SHBP Plan Design Committee adopted a resolution requiring the State to create a Center of Excellence (COE) program for certain surgical procedures. Labor representatives identified a single source vendor with a proven track record with other public sector clients, and that vendor was available from at least one multi-state cooperative purchasing programs in which the State of NJ is a participant. Procurement solicitation was not published until July 2025, a year after the PDC resolution was adopted.

→ *The State shall expedite all necessary procedures to ensure a COE provider is secured and the COE is installed no later than January 1, 2026. Should the State not implement this COE by that date, the savings between charges incurred prior to implementation and the cost of service under the COE will be counted towards reduction of the cost reduction requirement in the FY2026 budget.*

6. **Expand Centers of Excellence**

→ *Expand COE to include colonoscopies, cataract surgery, and other routine procedures as defined by the Plan Design Committee no later than October 1. Establish a single source Center of Excellence for transplants. Prices shall be set at the lower of billed charges, the TPA's contracted rate for the service, or 225% of CMS.*

→ *Pilot COE in year one with incentives, then implement higher-tiered copays if the procedure is done at a non-COE provider, for each procedure, in year 2 and year 3.*

→ *Specifically, in years one and two of the pilot program, members who utilize a Center of Excellence network provider to obtain a Covered Service shall have no out of pocket cost share. In year 3 of the pilot, members who have access to a COE, including geographic access as defined in PDC Resolution 2024-7 and can obtain an appointment within two months of the*

request, shall pay a copayment of $400. In year four and thereafter, the member meting these conditions will have a copayment of $500.

7. Competitive Plan Premium Rates

→ *The plan actuary will analyze and recommend rates for medical carriers based on each respective carrier's claims and trend data., i.e. Horizon and Aetna medical rates will be analyzed separately. The actuary will report revised premium rate recommendations for each respective TPA for PY2026 no later than August 15, 2026.*

8. Direct Primary Care Medical Home Referrals

→ *The Division shall require referrals, where applicable, from the SHBP Direct Primary Care Medical Home providers be directed only to providers included in Centers of Excellence as established under the SHBP.*

9. Evaluate care management programs that are not generating ROI and renegotiate prices or terminate.

C. Take Back Control of the Prescription Formulary

The State is losing out on rebates and paying higher drug prices by ceding bargaining power to its PBM. The pricing and rebate process is opaque, potential savings to the State are delayed. The end results are the State incurs huge costs and public employees are blamed for using high priced medications.

Labor continues to advocate for taking back control of the prescription formulary so the PDC and SHBC can act faster to adapt to new drugs entering the market and to negotiate the most advantageous rebates and discounts.

1. Audit all net prices for top 100 highest spend medications.
Labor strenuously recommends an audit of the net prices paid for the top 100 highest spend drugs no later than August 15, 2025 given recent reductions found on Amjevita and GLP1 prices. It is clear that manufacturer discounts are delayed reaching the SHBP formulary, despite the size of NJ's pool and leverage to negotiate.

Lilly started with direct-to-consumer pricing for Zepbound at $499 in January 2024 and Novo for Amjevita in March 2025. NJ is not realizing those prices until months later. It is clear there are savings NJ has left on the table.

We request an audit of all net prices to secure the best prices available on both the open market and manufacturer discounts or enhanced rebates, and to credit savings for Plan Year 2025 and Plan Year 2026 towards the $100M/$200M annualized reduction required in the FY2026 budget.

Further, we note with dismay that pricing offered to NJ is not more favorable given the size of our plan population. NJ should be receiving better pricing than what is available on the general market. We again urge NJ and the management side of the Plan Design Committee to work with Labor to take back control of the formulary to more aggressively negotiate prices.

→ *Audit the top 100 highest spend drugs to ensure all available discounts and maximum rebates are being applied. Apply reductions. Score savings achieved in Plan Year 2025 and Plan Year 2026 towards the FY2026 budget requirement.*

→ *In the private market, there is a 55% discount on Amjevita effective August 2025. Score savings achieved in Plan Year 2025 and Plan Year 2026 towards the FY2026 budget requirement.*

→ *Implement policy by PDC to audit all medications on quarterly basis for new rebates and discounts, comparing to private market.*

2. Clinical Effectiveness Based Formulary

→ *Pass the PDC resolution (attached). Require procurement solicitations to be issued by State within ninety days of PDC approval.*

3. Quarterly Review of FDA-approved medications

→ *On a quarterly basis, the PDC will review medications that have been newly approved by the FDA. A majority vote shall be required to add a new medication to the formulary.*

4. Reverse Auction the Prescription Drug Contract

As of 2022, the State saved $2.5 billion in prescription drug costs from two reverse auctions in the preceding five years. The State is overdue for a reverse auction now, by several years.

→ *The State shall reverse auction the prescription drug program no later than September 1, 2025 and every two years thereafter, with no extensions. Savings projected from reverse auction shall be credited towards the FY2026 budget requirement and towards reducing premiums for PY2026.*

5. GLP1s

As of January, the State does not use a counseling and monitoring program to dispense or administer weight loss medications. The member needs a prior authorization and a BMI of at least 30 or a BMI of 27 and one diagnosed comorbidity.

GLP1 drugs for obesity are among the top ten highest spend medications in the formulary.

→ End early refills for GLP1 anti-obesity medications, effective September 1, 2025. *Score savings achieved in PY2025 and projected for PY2026, score savings towards the FY2026 budget requirement.*

→ Implement a GLP1 anti-obesity counseling and monitoring program.
The counseling provider should have a fee structure based on measurable and documented improved health results, paid upon achieving those results.

The counseling provider should be contracted as the prescribing provider for all GLP1 anti-obesity treatments. There should be an assessment after 6 months of treatment, including BMI loss and other factors, whether to continue GLP1 treatments.

→ The Plan Actuary should score both Options 1 and 2 below.

a. Option 1: Implement three-tiered copay for GLP1s for anti-obesity, effective January 1, 2026:

Brand preferred:	$35/month
Brand non-preferred:	$50/month

b. Option 2: Reduce Plan payment for Wegovy to $447.05 per month or no more than 90% of best negotiated price by utilizing rebates and other cost savings measures. Implement as of 9/1/25 resulting in scored savings of $400 per Rx filled for 10 months.

For example, at an expected annual fill of at least 72,000 per year or 6,000 per month based upon conservatively calculated continuing increase in prescriptions filled. This calculation is 6,000 per month times 10 months or 60,000 Rx filled; that results in $24M on Wegovy alone by end of 1st 6 months of PY26.

6. Purchase certain higher cost medications directly from manufacturer or through FDA-approved alternative sources

FDA has approved purchases through importation. Florida is purchasing drugs by import from Canada, albeit for state-provided prescriptions such as disabled residents in medical facilities, Dept of Corrections, etc.

→ *Identify high spend drugs to negotiate to purchase medications directly from manufacturer*

7. Charge medications through least costly method

→Evaluate all medications charged through medical side of the program to determine savings if charged through prescription drug side. Require least costly method and score savings.

8. Biosimilars – Plan-Wide

→ *Audit top 100 highest spend drugs to identify available biosimilars.*
→ *Effective January 1, 2026, implement mandatory step therapy program to require biosimilars first prior to any originator drugs; those already on specialty shall continue "as is."*

9. **Review J Codes for the Rx products** used in treatment under the medical plan (often at the doctor's office) and move those to the Pharmacy Benefit Manager (lower pricing and rebate access). This can be done in phases and can exclude oncology drugs.

→ *Institute cap on Medical Drug Prices (J drugs) at 120% of Average Sale Price.*

10. Diabetes / Insulin

→ *The State shall determine if this treatment category can be pulled out of medical claims and handled separately at lower cost by a third party vendor.*

11. Formulary Controls
→ *As part of formulary management, the PDC shall two formulary advisors, one for general pharmaceuticals that will make suggestions based on comparative effectiveness research who will make recommendations to the PDC on the drugs included in the formulary based on clinical efficacy, and one to assist with specialty medicines who will assist providers in finding the most effective drug for the member's in their class. These vendors will have no financial conflicts and shall not be aligned in any way with the State's PBM or TPA's. They shall be paid strictly on a PMPM or case basis.*

SHBP PDC RESOLUTION # 2024-*

RESOLUTION OF THE STATE HEALTH BENEFITS PLAN DESIGN COMMITTEE TO ESTABLISH THE SHBP COMPARATIVE EFFECTIVENESS FORMULARY

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and Member premiums; and

WHEREAS, the State Health Benefits Commission (SHBC) contracts with a pharmacy benefit manager (PBM) to administer the pharmacy claims for the SHBP's plans; and

WHEREAS, with the exception of the Medicare Advantage plans, the SHBP's current PBM is OptumRx ("OptumRx");

WHEREAS, the costs for prescription drug benefits continue to increase significantly, which has strained the budgets of the State and local employers and caused increased costs to Members; and

WHEREAS, the major objectives of the SHBP Plan Design Committee (PDC) are to 1) contain costs for the Plan and its Members, while also 2) minimizing significant Member disruption; and 3) enhance the clinical quality of medications covered on the plan;

WHEREAS, a Formulary is defined as a list of Covered Medications, along with a set of Utilization Management policies that together lead to demonstrable reduction in the cost of care; and

WHEREAS, the current formulary promotes coverage of high cost medications in the pursuit of rebates, results in overall increased out of pocket costs to SHBP Members, and cannot ensure that the most effective medications are covered; and

WHEREAS, the current formulary requires SHBP Plan Design Committee to relinquish its control of the formulary design in exchange for rebate guarantees that promote excess use of lower value medications; and

WHEREAS, the SHBP Plan Design Committee believes that reclaiming control of its Formulary design and building the Formulary with a foundation of Comparative Effectiveness data, fully customized to meet the needs of the Members of the SHBP, will help to provide better clinical outcomes, to contain rising healthcare costs of medications, with the least possible disruption to Members, all without posing undue implementation challenges within the current SHBP structure; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State, local employers, and employees, to reclaim control of its Formulary to determine the impact on SHBP costs and Members' access to the highest effectiveness medications; and

WHEREAS, where appropriate and verifiable by the SHBP actuaries, the State and Unions desire to implement an effectiveness-based Formulary to impact the annual rate renewals for the SHBP; and

WHEREAS, the Plan Design Committee urges the SHBC and the Division of Pensions and Benefits to undertake all necessary steps, including but not limited to any procurement process deemed necessary or advisable, in the most expeditious and cost-effective manner possible, with the goal of launching its own Formulary as early as possible.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

The SHBP Plan Design Committee establishes a process for designing and monitoring the SHBP Comparative Effectiveness Formulary ("Formulary").

1. This Resolution shall apply to all SHBP Plans, including Medicare eligible retirees, offered to state employees and to local governments.
2. The Plan Design Committee will design a fully tailored, closed Formulary that must be implemented and administered in its entirety, and without modification, additions, or omissions by its PBM.
    a. The Formulary is considered a "closed" Formulary because only medications approved by PDC will be covered on the Formulary. The SHBP will provide regular updates to the PBM with medication coverage status.
3. The SHBP Comparative Effectiveness Formulary will include these features at a minimum:
    a. The Plan will set a new cost share tier, Tier 0, that will promote access to the highest quality medications to Members in the form of no cost share, which shall be applied to all PPOs, HMOs, HDHPs, and Tiered Network Plans offered to state and local government employees. The PDC will determine assignment of medications to other tiers within the formulary.
    b. Comparative Effectiveness and Utilization Management are considered components of the Formulary which shall also include but not be limited to coverage criteria for prior authorizations, appeals, quantity limits, age limits, etc. The Formularmust consider Comparative Effectiveness Research, as available, to ensure coverage of the best medications is promoted.
    c. Terms such as "Specialty" shall be defined by Plan Design Committee.
    d. Policies that determine status of Covered Medications shall be based on the highest quality Comparative Effectiveness Research, as available.
    e. Medication prices will be available and evaluated net of all discounts, including but not limited to contracted discounts, rebates, other manufacturer revenues.

4. When a Member files a claim for Tier 0 medication, the Member shall have no cost-sharing (i.e., copayments, deductibles, or coinsurance) as permitted by law.
5. In order for the SHBP to make the best decisions on behalf of its Members, the Rebate guarantee process will change to the following process:
    a. The Plan Design Committee will make Formulary decisions and provide the Formulary and any associated coverage or Utilization Management policy to its PBM
    b. The PBM will have 10 business days to respond with drug level rebate estimates and changes in guarantees, if any, disclosing all assumptions used to arrive at those estimates
6. All manufacturer and GPO revenue associated with SHBP pharmacy claims and received by PBM will be passed through 100% to SHBP with no deductions retained
7. PBM will provide reporting with each quarterly rebate payment that includes the amount of rebate received for each paid claim submitted, with claim level rationale for any claims submitted for rebates that did not receive rebates. PBM must provide rebate data in the State's designated reporting template, which may be modified from time to time in the State's sole discretion.
8. The Plan Design Committee reserves the right to independently source manufacturer and rebate contracts directly with manufacturers or other related entities.
9. The SHBP will engage a Formulary Advisor to support the design, implementation, and monitoring of the Formulary, which includes but is not limited to medication coverage and Utilization Management policies.
10. The Formulary Advisor must meet the following criteria:
    a. Proven expertise in Comparative Effectiveness Research ("CER") with in-house experts in meta-analysis and network meta-analysis
    b. The Formulary Advisor will have no conflicting relationships or sources of revenue (applies to the company and all affiliates):
        i. no ownership of entities that are part of the pharmaceutical supply chain, including but not limited to pharmacies (retail, mail, and specialty), Group Purchasing Organizations (GPOs), PBMs, pharmaceutical manufacturers; and
        ii. the company may generate no revenues from the following organizations, including but not limited to, pharmaceutical manufacturers, GPOs, PBMs, pharmacies (retail, mail, and specialty), consultants, or brokers.
        iii. The Formulary Advisor cannot currently serve as the SHBP's PBM or submit a proposal to be the SHBP's PBM.
    c. Past experience advising other state governments in integrating Comparative Effectiveness Research in Formulary design, implementation, and monitoring
    d. Proven track record of minimizing Member disruption
    e. Proven track record of developing formularies that have resulted in negative cost trends year over year
11. Formulary Advisor must be able to provide the following services:
    a. Formulary design based on CER, including but not limited to, medication coverage strategies, prior authorization criteria, appeal criteria, quantity limits, age limits, etc.

b. Provide regular reporting on medication net costs, including the impact of rebates at a drug level
c. Analyze potential savings with various Formulary designs and in consideration of potential Member disruption
d. Provide detail as requested by SHBP regarding the potential impact to Members, number of Members of affect, and options to consider that optimize for the best outcome for the Plan and Members
e. Develop and distribute tailored Member and physician communication that incorporates the CER-based rationale for coverage
f. Staff of clinical pharmacists trained in CER to be able to support inbound and outbound calls from Members and physicians
g. Provide PBM with the appropriate level detail for accurate coding of the Formulary to meet the specifications of SHBP
h. Oversight of PBM Formulary implementations and claims testing
i. Member and claim level post-implementation savings reporting

12. Upon the launch of the SHBP Comparative Effectiveness Formulary, the Division of Pensions and Benefits will provide quarterly verbal reports to the SHBP Plan Design Committee regarding pharmacy utilization, costs, and performance.
13. By approval of this Resolution, the superconciliation demand pursuant to the unapproved Resolution #2022-9 is hereby resolved.

DATED: [August 20], 2024